AUTHORIZATION FOR RELEASE OF

IDENTIFYING HEALTH INFORMATION

Hertneky Vision Source

# 212 Cameron Street Brush, CO 80723

970.842.5166

 Jennifer Flores, Privacy Official

Patient Name and DOB

Patient Address

Patient Phone Number

I authorize       to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

1. Detailed description of the information to be released: **Summary of Care that includes medications**
2. To whom may the information be released (name(s) or classes of recipients): **Hertneky Vision Source**
3. The purpose(s) for the release: **Medication Reconciliation**
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

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Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

Representative Relationship to Patient